PRINTED: 08/09/2008 DEPARTMENT OF HEALTH AND HUMA FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 295050 07/29/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 445 W. HOLCOMB LANE LIFE CARE CENTER OF RENO **RENO, NV 89511** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 000 INITIAL COMMENTS F 000 This Statement of Deficiencies was generated as a result of a complaint survey conducted at your This Plan of Correction is submitted as facility on 7/29/08. required under Federal and State regulations and statutes applicable to Complaint #NV00018821 alleged that the facility long term care providers. This Plan of failed to provide services and properly maintain Correction does not constitute an equipment. The complaint was substantiated. admission of liability on the part of the (See F 157 and F 281) facility, and such liability is hereby specifically denied. The submission of The findings and conclusions of any investigation this Plan does not constitute agreement by the Health Division shall not be construed as by the facility that the surveyor's prohibiting any criminal or civil investigations. findings or conclusions are accurate, actions or other claims for relief that may be that the findings constitute a deficiency, available to any party under applicable federal, or that the scope or severity regarding state or local laws. any of the deficiencies cited are F 157 483.10(b)(11) NOTIFICATION OF CHANGES F 157 correctly applied. SS=D A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an RECEIVED existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a

the resident from the facility as specified in

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(X6) DATE

Machelle Harri

Executive Director

8/19/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

§483.12(a).

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF RENO STREET ADDRESS, CITY, STATE, ZIP CODE 445 W. HOLCOMB LANE RENO, NV 89511 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE						-	С	
LIFE CARE CENTER OF RENO 445 W. HOLCOMB LANE RENO, NV 89511 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM-		295050 B. WING						
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM				445 W. HOLCOMB LANE				
DEFICIENCY)	(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL		(EACH CORRECTIVE AC CROSS-REFERENCED TO	(X5) COMPLETION DATE		
F 157 Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to notify the physician of abnormal bladder scan results for one resident. Findings include: Resident #1: The resident was admitted to the facility on 7/16/08 with diagnoses including debility, dysphagia, interstitial lung disease, status post thoracentesis, pulmonary effusion, chronic obstructive pulmonary disease, congestive heart failure, hypertension, diabetes, depression, anemia, and renal insufficiency. The resident was incontinent of bowel and bladder and was somewhat confused. According to the director of nursing (DON) the family expressed concern about the resident's voiding ability and requested a bladder scan be done on the resident on 7/16/08. Results of the bladder scan were recorded as 999 cc's on two separate times on 7/16/08. Review of the Bladder Scanner BVI 3000 Policy and Procedure revealed at Procedure #13 that "The nurse is responsible to report to the	F 157	change in room or specified in §483.1 resident rights under regulations as specithis section. The facility must rethe address and phagal representative. This REQUIREMED by: Based on record refacility failed to notibladder scan result. Findings include: Resident #1: The refacility on 7/16/08 with debility, dysphagia, post thoracentesis, obstructive pulmon failure, hypertension anemia, and renal in the resident was in bladder and was so to the director of nuexpressed concernability and requested the resident on 7/16 scan were recorded times on 7/16/08. Review of the Blada and Procedure reversion.	roommate assignment as 5(e)(2); or a change in er Federal or State law or cified in paragraph (b)(1) of cord and periodically update one number of the resident's or interested family member. NT is not met as evidenced view, it was determined the fy the physician of abnormal s for one resident. esident was admitted to the vith diagnoses including interstitial lung disease, status pulmonary effusion, chronic ary disease, congestive heart in, diabetes, depression, insufficiency. Incontinent of bowel and imewhat confused. According in the resident's voiding about the resident's voiding abou	F 157	a) Resident #1 was acute care facilit b) Residents received have been review proper physician scans showed at requiring physical Therefore, no other affected by practice (see extended by practice (see extended by practice). c) Nurses have been regarding physical abnormal bladded exhibit #2). d) DON or designed random bladder ensure proper not physician regardersults (see exhibit Committee to remonthly to ensure notification untite).	s discharged to an ty. Fing bladder scans wed to ensure a notification. No conormal results consider residents have to this deficient abilitially. Fine educated con notification of the scan results (see the will audit scan results to cotification of thing abnormal bit #3). Pleview audits are proper lithreshold is met.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING			С	
		295050	B. WII	NG	07/2		9/2008
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF RENO		STREET ADDRESS, CITY, STATE, ZIP CODE 445 W. HOLCOMB LANE RENO, NV 89511					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI ROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 157 F 281 SS=D	physician if finding of greater that 400 miles cubic centimeter. Cross reference F 2 483.20(k)(3)(i) COM The services provide must meet profession. This REQUIREMENT by: Based on interview determined the facion physician's order for assess and interverscans, failed to noti	of the post void residuals are liliters." (Milliliters is the same rs.) 281 Professional Standards MPREHENSIVE CARE PLANS and or arranged by the facility conal standards of quality. NT is not met as evidenced and record review, it was lity failed to obtain a r a bladder scan, failed to be on the results of bladder fy the physician of abnormal s, and failed to maintain test manufacturer's		281	F 281 COMPREHENSIVE PLANS a) Resident #1 was discharacute care facility. b) Residents receiving blad have been reviewed to ephysician's orders have obtained, scan results has assessed and proper inte taken, and physician not was not necessary as the abnormal results (see ex The scanner has been prealibrated. No other resifound to have been affect deficient practice.	der scans insure that been ve been rventions ification re were no hibit #1). operly dents were	
	facility on 7/16/08 w debility, dysphagia, post thoracentesis, obstructive pulmona failure, hypertension anemia, and renal in The resident was in bladder and was so to the director of nu expressed concern ability and requeste the resident on 7/16	esident #1: The resident was admitted to the scility on 7/16/08 with diagnoses including ebility, dysphagia, interstitial lung disease, status ost thoracentesis, pulmonary effusion, chronic ostructive pulmonary disease, congestive heart silure, hypertension, diabetes, depression, nemia, and renal insufficiency. The resident was incontinent of bowel and adder and was somewhat confused. According to the director of nursing (DON) the family expressed concern about the resident's voiding collity and requested a bladder scan be done on the resident on 7/16/08. Results of the bladder scan were recorded as 999 cubic centimeters.			c) Nurses have been educate regarding obtaining physical orders for bladder scans, and intervening appropriated on scan results, and physician notification real abnormal scan results (s. #2). The Bladder Scanner BV was sent to the manufact proper calibration, and a has been developed to estimely calibrations as spin manufacturer's recommendation (see exhibit #4).	sician's assessing iately id garding ee exhibit // 3000 turer for schedule nsure ecified by	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ULTIPLE CONSTRUCTION LDING	COMPLI	(X3) DATE SURVEY COMPLETED	
	295050		B. WIN	/G		C 29/2008	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF RENO			STREET ADDRESS, CITY, STATE 445 W. HOLCOMB LANE RENO, NV 89511	E, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE	
F 281	(cc's) on two separaresident voided a re 269 cc's. The reside cramping and a nu and obtained 95 cc' capacity is between bladder can normal before the urge to verificate the urge to ve	rate times on 7/16/08. After the epeat scan yielded a result of ent complained of abdominal urse catheterized the resident is of urine. Normal bladder in 400-600 cc's. The urinary lly hold 250 to 350 cc's of urine void becomes conscious. der Scanner BVI 3000 Policy ealed Procedure #13 that read onsible to report to the of the post void residuals are illiliters. A review of the residuals are in April of 2007. In failed to reveal evidence of for the bladder scanner revealed ted every six months using mg to the DON the scanner in April of 2007. In failed to reveal evidence of for the bladder scan, and no cian was notified of any of the complete and at other times. Commentation of fluid intakes intakes between meals were never was a written statement de regarding fluid intake of the neals. The resident was the time, with some nence. There were no urinary output. A statement by indicated the resident voided dithe resident was changed	F 2	d) DON or design random bladd proper MD or intervention because it into the scan, notificator egarding about timely calibra (see exhibit #5	der scans to ensure rders, assessment and pased on results of tion of physician normal results, and ation of equipment 3). PI Committee to monthly until net.		

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CENTERS FOR MEDICARE & MEDICAID SE	RVICES

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER	233030	1	071	DEET ADDRESS OFFI OTATE TO CODE	07/2	9/2008	
LIFE CARE CENTER OF RENO			4	REET ADDRESS, CITY, STATE, ZIP CODE 145 W. HOLCOMB LANE RENO, NV 89511				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 281	The record revealed vomited four times diarrhea. His vital so The family visited a resident seemed must be family requested physician and the family requested physician and the family requested physician and the family requested to the highest family resident transferred to the highest family fa	d that, on 7/20/08, Resident #1 during the day and had igns were within normal limits. Ind informed the nurse the ore confused and lethargic. Ind the nurse notify the amily preferred the resident be ospital. The physician ordered red to the hospital at 4:45 PM pital admission record of at the history and physical ed significant dehydration and writis. Resident #1 was Emergency Department and a of dark yellow urine was cian indicated the resident c hypertrophy with a bladder the resident was placed on IV to the acute care facility.	F:	281				

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